MDR Tracking #M4-04-4148-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 12/4/03.

I. DISPUTE

Whether there should be reimbursement for CPT code E1399 (Durable Medical Equipment-RS4i Muscle Stimulator) for dates of service 8/13/03 and 9/13/03.

II. RATIONALE

Date of service 8/13/03 was denied as, "F Z560-The charge for this procedure exceeds the fee schedule or usual and customary as established by Ingenix." Date of service 9/13/03 was denied as "X170-Pre-Authorization was required, but not requested for this service per TWCC Rule 134.600."

Requestor states that, "There is no established fee schedule for this device" and "Preauthorization not required, line item does not exceed $500.00."

Carrier's response, dated 12/16/03, states, "Charges in dispute were paid at a fair and reasonable rate." There was no response regarding the preauthorization denial.

Commission Rule 134.600 (h) (11) states that, "The non-emergency health care requiring preauthorization includes: All durable medical equipment (DME) in excess of $500 per item (either purchase or expected cumulative rental) and all transcutaneous electrical nerve stimulators (TENS) units;" and Rule 133.307 (j)(F) states, "If the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and 133.1 and 134.1 of this title."

The Requestor provided redacted EOB's that supported charges billed and reimbursed by other carriers that demonstrated the amount the Carrier paid was not fair and reasonable. Additional reimbursement is recommended for date of service 8/13/03 for $100.00. Date of service 9/13/03 was billed for one month rental at $250.00. Per Rule 134.600(h)(11) reimbursement is recommended for $250.00.

III. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor is entitled to reimbursement for CPT code E1399 in the amount of $ 350.00. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit $350.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 22nd day of March 2004.

Terri Chance
Medical Dispute Resolution Officer
Medical Review Division

TC/tc